DOCUMENT RESUME

ED 345 126 CG 024 191

AUTHOR Zimmerman, James K.; La Sorsa, Valerie A.
TITLE Being the Family's Therapist: An Integrative Approach.
PUB DATE Apr 92
NOTE 22p.; Paper presented at the Annual Conference of the American Association of Suicidology (25th, Chicago, IL, April 1-4, 1992).
PUB TYPE Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Adolescents; Counseling; Counseling Techniques; *Depression (Psychology); *Family Counseling; Family Relationship; *Suicide; Systems Approach

ABSTRACT

There is strong justification in the counseling literature for bridging individual and family perspectives. The Adolescent Depression and Suicide Program at Montefiore Center/Albert Einstein College of Medicine (New York) is a brief treatment, outpatient clinic designed to provide mental health services for suicidal adolescents and their families. At the clinic there has been a concerted effort to develop and implement treatment approaches for this population that can exert powerful therapeutic leverage quickly. Two central treatment principles frequently employed in treatment in the clinic are: a suicide attempt in adolescence can be understood as a problem-solving behavior; and the speed at which separation and individuation occur, and whether the adolescent and the family are in synchrony regarding the rate of this process, are often aspects of the problem at hand. The approach to treatment at the clinic integrates family systems, developmental, and psychodynamic theoretical perspectives in a technical combination of individual and family modalities, which can be effective in treating suicidal adolescents. Ultimately, such an approach can allow the family as a system to move ahead at a mutually acceptable rate. What can be achieved is a successful renegotiation of relationships which allows the adolescent to move into adulthood while retaining connectedness with the family. This renegotiation also allows the family to experience individuation within the context of strong interpersonal bonds. (LLL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED345126

BEING THE FAMILY'S THERAPIST: AN INTEGRATIVE APPROACH

James K. Zimmerman, Ph.D.
Valerie A. La Sorsa, M.A.
Department of Psychiatry
Montefiore Medical Center/
Albert Einstein College of
Medicine
111 E. 210th St.,
Bronx, NY 10467
(212) 920-4352

Presented at the 25th Annual Conference of the American Association of Suicidology, April, 1992, Chicago, IL

CG024191

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

James K. Zimmerman

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

BEST COPY AVAILABLE

Being the family's therapist: An integrative approach

In the past fifteen years, there has been a powerful movement toward integrating approaches to psychotherapy, on the levels of both theoretical constructs and technical interventions (Beitman et al, 1989; Norcross and Grencavage, 1989; Arkowitz, 1991; Lazarus and Messer, 1991). One area in which integration has been particularly active is in combining individual and family treatment (Carter, 1987; Guerney and Guerney, 1987; Turgay, 1989; Case and Robinson, 1990; Kaslow and Racusin, 1990). Although there are those who continue to debate the wisdom of this movement (Haley, 1987; Nichols, 1987), there is a growing body of literature suggesting that integration, both theoretically and technically, is becoming acceptable and respected by a wide range of clinicians from various schools of thought (Beitman et al, 1989; Wachtel, 1991; Karasu, 1979; Pinsof, 1983; Feldman, 1985).

In this paper, we will present and discuss a model for integrating different treatment modalities and theoretical positions in interventions with suicidal adolescents and their families in a brief treatment context. With respect to modalities, we integrate individual and family approaches, while in some cases including couples sessions with the adolescent's parents. Regarding theoretical integration, we have found that an approach drawing upon family systems, psychodynamic, and developmental perspectives best potentiates our ability to make significant therapeutic strides.

There is strong justification in the literature for bridging

individual and family perspectives. Wachtel and Wachtel (1986) maintain that "...neither the dynamics of individuals or the context in which they operate can be ignored, and that the two codetermine each other in ways that it is essential to understand" (p. 2). With respect to the treatment of children and adolescents, other authors repeatedly cite the need to integrate theoretical perspectives, in order to understand the complexity of individual behavior and family functioning (Kirschner and Kirschner, 1986) and to end the limiting effects of exclusivity in theoretical conceptualization (Nichols, 1987). Levant and Haffey (1981) maintain that "the child needs to be seen within the context of his/her family, yet the child (as well as the parents) exists not only as a member of the family system, but also as an individual at a certain stage of development in his/her life cycle" (p. 139).

In the technical realm, we find that a fluid approach most suits the needs of the cases seen in our clinic. This approach integrates modalities, is dictated by the issues that arise during the course of treatment, and is implemented by a single therapist. Early in the literature on treatment integration, Kaffman (1965) and Charny (1966) separately advocated such a flexible treatment approach to meet the diverse needs of families and individuals. Charny proposed "a psychotherapy where individual and family interviews are utilized concurrently in a flexible, unfolding sequence that grows out of the flow or movement of each particular case" (1966, p. 179).

In the remainder of this paper, we will outline how this

approach functions in our work. Initially, we will describe the clinical context in which this treatment approach has evolved. Following that, we will present some of the fundamental dynamics which we see as central to the experience of suicidal adolescents and their families, illustrating with case materials the ways in which this understanding influences our psychotherapeutic approach. Finally, we will discuss some relevant technical issues which arise in the context of the approach to treatment which we advocate.

The Clinic

The Adolescent Depression and Suicide Program (ADSP) at Montefiore Medical Center/Albert Einstein College of Medicine is a brief treatment, outpatient clinic designed to provide mental health services for suicidal adolescents and their families. The population largely derives from underprivileged, minority, inner-city backgrounds; many of the families have only one biological parent in the household, most often the mother, and acrimonious relationships between the biological parents are common. Typically, adolescents are referred to the clinic soon after they have made a suicide attempt.

The clinic provides crisis intervention, extensive evaluation, and time-limited psychotherapy to these adolescents and their families. Because the stay in treatment is limited to approximately three months, there is strong pressure to accomplish as much as possible in a short period of time. As a result, there has been a concerted effort to develop and implement treatment approaches for this population which can exert powerful therapeutic

leverage quickly.

It is within this crucible, then, that our approach to treatment has been formed, and we have found that the most effective stance in treatment is to position ourselves as the "family's therapist". Our intent is to be of service to the family system either as a whole or in various constituent parts, much as a trusted family doctor treats each and all members of a family (Kirschner and Kirschner, 1990; Vane and DeMaria, 1988). In this way, we are able to gain direct access quickly not only to the systems issues at hand, but also to salient individual and subsystem (e.g., couples) issues.

Fundamental Dynamics

In recent years, a substantial body of literature has related suicidality in adolescents to family issues. Research has shown that family problems are frequently considered a major precipitant in suicide attempts among adolescents (Pfeffer, 1989; Spirito et al, 1989; Tishler, McKenry, and Morgan, 1981). Specifically, family disruptions, including losses (through divorce, absence, and death) and physical and sexual abuse, have been found to relate strongly to attempted and completed suicide (Pfeffer, 1989; Shaffer, 1974; Shafii, 1985; Spirito et al, 1989; Landau-Stanton and Stanton, 1985).

In agreement with Fishman (1988), it is our contention that adolescents in general cannot be understood outside the context of their family systems and their developmental issues; similarly, the family systems of adolescents must also be regarded as developing

entities which are influenced profoundly by the behavior of the adolescents within them. Given that one of the developmental tasks of adolescence is separation and individuation from the family, we believe that healthy families participate in this process by negotiating conflicts, regulating closeness, and balancing increased autonomy with age-appropriate limits (Jurkovic and Ulrici, 1985; Kaslow and Racusin, 1990).

Unfortunately, some families do not function in this "healthy" way without outside assistance. With specific regard to adolescent suicide attempters, it is apparent that the behavior of these individuals is quite often strongly influenced by family dynamics, and, conversely, that a suicide attempt by an adolescent also has a powerful impact on the development of his or her family system. It follows logically, then, that a combined focus on family systems issues, individual dynamics, and developmental imperatives is the optimal method for treating suicidal adolescents and their families in a brief treatment context.

Given the limited scope of this paper, however, it is not possible to describe the rationales and treatment approaches used in the ADSP in full. Therefore, we would like to focus upon two central principles frequently employed in treatment in the clinic. Simply put, these are: 1) A suicide attempt in adolescence can be understood as a problem-solving behavior (see also Orbach, 1986, 1988); and 2) the speed at which separation and individuation occur, and whether the adolescent and the family are in synchrony regarding the rate of this process, are often aspects of the

problem at hand (see also Boscolo and Cecchin, 1982, and Gustafson, 1986). These two principles are closely allied, and will be addressed concurrently.

Adolescents and families can be seen as a system in development, with each individual needing to evolve in synchrony with the others for equilibrium to be maintained. Often, however, one or another family member moves at a faster rate than the others, causing a crisis to occur. There are several ways in which this can be manifested: First of all, the adolescent may be moving too quickly into adult choices and peer activities for the parents, or the adolescent may feel that the parents are expecting him or her to take on adult responsibilities prematurely. Secondly, an adolescent may feel the need to slow progress, refusing to participate in normal, expected activities such as school and social interactions. Third, he or she may feel so constrained by family pressures that opting out of the developmental process entirely seems like the only plausible choice.

In addition, successful negotiation of the developmental tasks of adolescence can be impeded by open wounds or damage, such as the sequelae of physical or sexual abuse, adversarial relationships between parents, and so on. Finally, adolescents are sometimes not sure that their parents are ready for their departure, or that the marriage will survive; likewise, parents are not always secure in the feeling that their children are equipped to move into relationships beyond the family.

The above scenarios all relate to the "rate-of-development"

principle. It is quite apparent that there are a number of ways in which an adolescent and his or her parents could feel at odds with each other, and that problems could easily arise. Often, these problems can pit the adolescent's forward movement into adulthood against his or her desires to remain a child and be nurtured. In addition, there can be circumstances in which the adolescent feels pulled in two directions at once by conflicting messages from parents, either between the parents or within each of them.

Such circumstances can engender the feeling in the adolescent that their current problems are insurmountable. What we suggest is that a suicide attempt in adolescence can be understood as an attempt to solve a problem with developmental overtones which is experienced as having no solution. We have observed time and again that adolescents who make suicide attempts experience themselves as being in circumstances from which there is no clear path to extrication, and that the suicide attempt is at least in part a way of resolving this dilemma. In general, these "insolvable problems" (Orbach,1986, 1988) appear related to the rate-of-development principle.

For example, seventeen-year-old Roseanne, the youngest of four children in an intact Irish/Italian family, was referred to the ADSP after her second suicide attempt in as many years. Her parents had a long history of marital discord, and Roseanne and her mother were closely interconnected. When Roseanne made strides toward a life independent of her mother, her mother objected. For

her part, Roseanne worried a great deal about her mother, who had a history of suicidal behavior as well; she was unsure whether her parents' marriage would survive when she left home, or whether her mother would survive at all. Loyal to her mother, Roseanne stayed home a great deal, but became increasingly depressed; she felt torn between her desire to move on with her life and her mother's implicit demand that she remain her "baby". Faced with this "insolvable problem", she ingested a number of pills and went to sleep, informing no one of her action until the following day.

Such dilemmas can be categorized as follows, in the voice of the adolescent: 1) What happens if/when I leave? Will my parents survive it (together or separately)? If I want to come back, will there be a home for me to return to? 2) I don't want to grow up, and my parents are making me move too fast; don't they care about me? 3) I want to grow up and my parents won't let me; why are they treating me like a much younger child? 4) My parents can't agree on what I'm supposed to do, who I'm supposed to be. How can I deal with this without betraying one or the other of them? 5) My parents won't let me be who I want to be. How can I be myself without losing them?

In all of the above circumstances, the suicidal adolescent experiences these developmental dilemmas as unresolvable: In essence, he or she feels that it is not possible to grow up without significant loss or betrayal, nor is it possible to stay a child without significant loss or betrayal. Growing up implies the loss of protection and nurturance that the family can provide; staying

a child implies the loss of the prerogatives of adulthood and the potential to discover and explore one's capabilities.

Although apparently insolvable, these developmental dilemmas are in fact not without resolution, but do call for flexibility. This requires the understanding that compromises must be made, that losses will inevitably be incurred while gains are solidified. In order to evolve into a fully-functioning adult, an adolescent does need to move away from the family, which implies a loss of the kind of connectedness that prevails in earlier life (Garcia Preto, 1988). However, as is suggested by more recent writings on adolescent development (Fishman, 1988; Apter, 1990), healthy evolution in the family does not require that adolescents and their parents disengage entirely. In fact, for both the adolescent and the family, separation and individuation can occur and flourish within a context of connectedness. In this way, the adolescent and his or her parents are able to create a more flexible relationship that will allow for further personal and systemic growth without rupture and isolated disengagement.

For example, Elsie, who was the youngest of three children in a traditional Puerto Rican family, was significantly depressed. After her second suicide attempt, she expressed concerns about her parents' fragile marriage and her anticipation of "growing up and being alone". As a result, her parents moved Elsie's bed into their bedroom, where her mother could keep a closer watch on her. This sleeping arrangement, which appeared protective of Elsie, also precluded any intimacy between her parents. In couples sessions,

Elsie's parents were helped to communicate more effectively, working through some of their resentments and disappointments. Consequently, they became willing to move Elsie back to her own room. When this was presented to her, however, Elsie "put on the brakes", feeling left out and rejected. In subsequent individual and family sessions, treatment focussed upon developing a more flexible, age-appropriate relationship between Elsie and her mother, so that they could function separately while maintaining the connectedness of their mother/daughter relationship.

The task of separating while maintaining connectedness is difficult to attain, however. When the adolescent has needed to slam on the brakes in order to alter a rate of development which was intolerable, the pace of development in the family often moves into retrograde. Adolescent and parents alike feel manipulated, controlled, or intruded upon, their needs and feelings disregarded (Zimmerman, 1991). Movement through time has stopped for such a family (Garcia Preto, 1988).

Consequently, in order to access the developmental derailment in the family system as a whole, and to remove the onus from one or another family member, therapeutic intervention is often required. One way we frequently address this need is to reframe the struggle between parents and adolescent in terms of the speed at which development is occurring, and what various members of the system are doing in order to regulate it.

For example, in the Vasquez family, the parents espoused relatively traditional Latino values. They felt that their three

adolescent daughters were moving too fast, getting involved in peer activities and sexual behavior that they were too young for. The girls felt that their parents were not able to understand them, could not see that their behavior was not meant as disrespectful or rebellious, but was more an expression of the experimentation that adolescents normatively go through. The daughters' way of expressing this concretely was to refuse to get out of bed in the morning; all three missed numerous days of school this way. Following a couples session, the parents began to attend more to their relationship separate from their children, apparently taking to heart the idea that their daughters would move on into adulthood and that they needed to focus on how their lives would be after their children were gone. In turn, the daughters were able to articulate their feelings, and were able to get on with their lives in school.

However, as things seemed to be improving, the middle daughter reported this incident: One night after eleven PM, she repeatedly entered her parents' bedroom in order to retrieve one or another thing she needed (such as a hairbrush); her parents finally "kicked (her) out". As a result, she felt she was being thrown out of the nest; in a family session, she said, "They're going to leave me, they don't care anymore". In response, the therapist suggested that her parents' choice to move on with their lives might have made her feel that they were going too fast for her, that she wasn't ready for this change yet. This intervention, and others like it, allow all members of the family to become aware of the

concept of the speed of development. As a result, they can make more conscious and informed choices about the rate at which they can agree to move ahead.

Technical Issues

The treatment approach we employ, although often effective, requires that certain technical issues be considered carefully. These include: 1) Approach to transference manifestations; 2) issues regarding confidentiality; 3) direct exposure of adolescents to toxic parental attitudes; and 4) potential dilution of family work through addressing family issues in separate individual sessions.

Transference Manifestations--Many authors express the concern that, in using a single therapist for individual and family treatment, the transference may be less fully developed or less intense than it would be in individual treatment alone (Charny, 1966; Glick et al, 1987). Although this may be the case if one were intent upon allowing a classical transference to develop, our treatment is offered over a short period of time. In such brief treatment contexts, a number of authors have suggested that transference manifestations should be interpreted or confronted as soon as they arise so that they will not become central to treatment (Mann, 1973; Alexander and French, 1946; Sifneos, 1979). Further, we position ourselves as the "family's" therapist, as contrasted with the family therapist, so that we may allow the family to develop a more systemic transference to us as facilitators of their growth as a group as well as individually.

Confidentiality--Managing confidentiality in the context of treatment which integrates individual and family modalities is not a simple task. In general, our approach is to delineate in the initial appointment with the family the limits to confidentiality regarding risk to self or others, or current physical or sexual abuse. In addition, we make it clear that treatment-destructive secrets cannot be kept by the therapist. However, there are instances in which information is told to us in a session with a sub-unit of the family which we do not feel is necessary to bring to light in a family session.

For example, Anna, age 15, reported in an individual session that she had been sexually abused as an eight-year-old by a maternal aunt. She stated that she was not ready to discuss this experience with her family, feeling concerned about the consequences. Since the abuse was not current, the choice was made to respect her wishes. Simultaneously, the therapist offered Anna help in disclosing this to the family if she chose to do so in the future.

In another case, however, the choice was made to inform the family of a confidential issue. Debbie, age 18, had a history of drug and alcohol abuse along with several serious suicide attempts. In an individual session, she revealed that she had begun drinking again, and had lied to her parents about it. The therapist explained that this information could not be kept confidential because of the potential risk to Debbie. Although she initially resisted, Debbie was willing to share this with her parents with

the help of the therapist. Her parents responded in a supportive way, and her father, a recovered alcoholic himself, was identified as an "expert" in this area. His help was solicited in monitoring Debbie's behavior. This intervention improved the relationship between father and daughter, and also brought the father into the family system in a more active way. His self-esteem and sense of efficacy grew as a result.

Toxic Attitudes--Some authors have expressed concern about the "traumatic effects on children of being explicitly confronted with implicit dangers in their intrafamilial relationships--such as the hostile, rejecting feelings of a parent" (Malone, 1979, p. 4). However, it is our experience that it is often better to bring these issues to light so that they can be managed therapeutically, especially in the aftermath of a suicide attempt. In fact, it is frequently the case that the adolescent has already intuited the feelings of the parent, and that these feelings actually become less destructive when they can be expressed in a controlled environment such as the therapist's office.

In the Vasquez family, described above, the oldest daughter, Anna, had become pregnant and suffered a miscarriage early in treatment. Although Anna's pregnancy was deeply disturbing to her parents, they did not express their feelings directly; rather, the issue came out in cryptic side-comments. In family sessions, the therapist encouraged the parents to express their disappointment more openly, which they proceeded to do. This culminated in a dramatic session in which Anna screamed at her parents that they

could not possibly understand her, and that she desperately missed her baby. She was then comforted by her younger sister, and, more tentatively, by her mother. In subsequent sessions, all family members were able to articulate their ambivalent feelings about her pregnancy and other behavior, and a stronger, more positive bond was reformed between Anna and her parents.

Dilution of Intensity--Finally, some authors suggest that the intensity of family issues may be diluted if they are raised in individual sessions (e.g., Fishman, 1988). However, we have found that it is often in such individual sessions that issues can be more fully expressed initially. In fact, this is sometimes the only context in which an adolescent will open up at all. Likewise, in separate sessions, parents may feel freer to speak more objectively about their roles as parents (Garcia Preto, 1988). Again, as is the case with unspoken toxic feelings, therapeutic leverage can be gained by exploring such concerns in the controlled context of the treatment room. As a result of such exploration, these concerns can be clarified with the adolescent or the parents without the confusion, distraction, and emotional intensity that sometimes ensue in family sessions. Subsequently, once the issues have been articulated, they can be brought into family meetings with the assistance of the therapist, to the greater benefit of all concerned.

For example, Roseanne, mentioned above, remained sullen and withdrawn in family sessions, unwilling to reveal the reasons for her suicide attempts. In an individual session, she admitted that

she felt she was a burden to her family, and that they would be better off without her. With encouragement, she chose to allow the therapist to use this information in a family session, although she was unable to do so herself. When informed, her parents were surprised and upset, but responded empathically; her mother, generally stoic and resistant, cried when she imagined her life without Roseanne. In addition to opening up new and positive lines of family communication, the revelation of Roseanne's feelings allowed her siblings to share similar ones.

Conclusion

In conclusion, we have presented some theoretical perspectives and technical issues regarding an integrative approach to the treatment of suicidal adolescents and their families in a brief treatment context. We have suggested that the dynamics of the "insolvable problem" and the rate of development of the adolescent and family are often central in such cases. Consequently, our approach to treatment integrates family systems, developmental, and psychodynamic theoretical perspectives in a technical combination of individual and family modalities, which can be effective in treating suicidal adolescents. Ultimately, in our view, such an approach can allow the family as a system to move ahead at a mutually acceptable rate of speed. What can be achieved is a successful renegotiation of relationships which allows the adolescent to move into adulthood while retaining connectedness with the family. This renegotiation also allows the family to experience individuation within the context of strong interpersonal bonds.

REFERENCES

Alexander, F., and French, T.M. (1946). Psychoanalytic Therapy: Principles and Applications. New York: Ronald Press.

Apter, T. (1990). Altered Loves. NY: St. Martin's Press.

Arkowitz, H. (1991). Introductory statement: Psychotherapy integration comes of age. J. Psychother. Integration, 1(1), 1-3.

Beitman, B.D., Goldfried, M.R., and Norcross, J.C. (1989). The movement toward integrating the psychotherapies: An overview. Am. J. Psychiatry, 146(2), 138-147.

Boscolo, L., and Cecchin, G. (1982). Training in systemic therapy at the Milan Center. In R. Whiffen and J. Byng-Hall, eds. Family Therapy Supervision: Recent Developments in Practice. London, UK: Academic Press.

Carter, C. (1987). Some indications for combining individual and family therapy. Am. J. Fam. Therapy, 15(2), 99-110.

Case, E.M., and Robinson, N.S. (1990). Toward integration: The changing world of family therapy. Am. J. Family Therapy, 18(2), 153-160.

Charny, I.W. (1966). Integrated individual and family psychotherapy. Family Process, 5(2), 179-198.

Feldman, L.B. (1985). Integrative multi-level therapy: A comprehensive interpersonal and intrapsychic approach. J. Mar. Fam. Therapy, 11, 357-372.

Fishman, H.C. (1988). Treating Troubled Adolescents: A Family Therapy Approach. New York, NY: Basic Books.

Garcia Preto, N. (1985). Transformation of the family system in adolescence. In B. Carter and M. McGoldrick, eds., The Changing Family Life Cycle: A Framework for Family Therapy, 2nd ed. NY: Gardner Press.

Glick, I., Clarkin, J., and Kessler, D. (1987). Marital and Family Therapy, 3rd ed. Orlando, FL: Gruner Stratton.

Guerney, L., and Guerney, B. (1987). Integrating child and family therapy. Psychotherapy, 24(3S), 609-614.

Gustafson, J.P. (1986). The Complex Secret of Brief Psychotherapy. New York, NY: Norton.

Haley, J. (1987). The disappearance of the individual. Fam. Ther. Networker, 11, 39-40.

Jurkovic, G.J., and Ulrici, D. (1985). Empirical perspectives on adolescents and their families. In L. L'Abate, ed., The Handbook of Family Psychology and Therapy, vol. 1. Homewood, IL: Dorsey Press.

Kaffman, M. (1965). Family diagnosis and therapy in child emotional pathology. Family Process, 4, 241-258.

Karasu, T.B. (1979). Toward unification of psychotherapies: A complementary model. Am. J. Psychotherapy, 33(4), 555-563.

Kaslow, N.J., and Racusin, G.R. (1990). Family therapy or child therapy: An open or shut case. J. Fam. Psychol., 3(3), 273-289.

Kirschner, D.A., and Kirschner, S. (1986). Comprehensive Family Therapy: An Integration of Systemic and Psychodynamic Treatment Models. NY: Brunner/Mazel.

Kirschner, S., and Kirschner, D.A. (1990). Comprehensive family therapy: Integrating individual, marital, and family therapy. In F. Kaslow, ed., Voices in Family Psychology, vol. 2. San Francisco: Sage.

Landau-Stanton, J., and Stanton, M.D. (1985). Treating suicidal adolescents and their families. In B. Carter and M. McGoldrick, eds., The Changing Family Life Cycle: A Framework for Family Therapy, 2nd ed. NY: Gardner Press.

Lazarus, A., and Messer, S. (1991). Does chaos prevail? An exchange on technical eclecticism and assimilative integration. J. Psychother. Integration, 1(2), 143-158.

Levant, R.F., and Haffey, N.A. (1981). Toward an integration of child and family therapy. Intl. J. Fam. Therapy, Summer, 130-142.

Malone, C.A. (1979). Child psychiatry and family therapy: An overview. J. Am. Acad. Child Psychiatry, 18, 4-20.

Mann, J. (1973). Time-Limited Psychotherapy. Cambridge, MA: Harvard Univ. Press.

Nichols, M. (1987). The individual in the system. Fam. Ther. Networker, 11, 33-38.

Norcross, J.C., and Grencavage, L.M. (1989). Eclecticism and integration in counselling and psychotherapy: Major themes and obstacles. Brit. J. Guid. Couns., 17, 227-247.

Orbach, I. (1986). The 'insolvable problem' as a determinant in the dynamics of suicidal behavior in children. J. Am. Psychotherapy, 40(4), 511-520.

Orbach, I. (1988). Children Who Don't Want To Live. San Francisco, CA: Jossey-Bass.

Pinsof, W. M. (1983). Integrative problem-centered therapy: Toward the synthesis of family and individual psychotherapies. J. Mar. Fam. Therapy, 9, 19-35.

Pfeffer, C.R. (1989). Life stress and family risk factors for youth fatal and nonfatal suicidal behavior. In C.R. Pfeffer, ed., Suicide Among Youth: Perspectives on Risk and Prevention. Washington, DC: American Psychiatric Press.

Shaffer, D. (1974). Suicide in childhood and early adolescence. J. Child Psychol. Psychiatry, 15, 275-291.

Shafii, M., Carrigan, S., Whittinghall, J.R., et al (1985). Psychological autopsy of completed suicide in children and adolescents. Am. J. Psychiatry, 142, 1061-1064.

Sifneos, P.E. (1979). Short-Term Dynamic Psychotherapy. New York: Plenum.

Spirito, A., Brown, L., Overholser, J., and Fritz, G. (1989). Attempted suicide in adolescence: A review and critique of the literature. Clin. Psychol. Review, 9, 335-363.

Tishler, C.L., McKenry, P.C., and Morgan, K.C. (1981). Adolescent suicide attempts: Some significant factors. Suic. Life-Threat. Behavior, 11, 86-92.

Turgay, A. (1989). An integrative treatment approach to child and adolescent suicidal behavior. Psych. Clin. N. Am., 12(4), 971-985.

Vane, J.R., and DeMaria, T. (1988). The psychologist as general family practitioner. Prof. Psychol.: Research and Practice, 19(1), 118-120.

Wachtel, P.L. (1991). From eclecticism to synthesis: Toward a more seamless psychotherapeutic integration. J. Psychother. Integration, 1(1), 43-54.

Wachtel, P.L., and Wachtel, E.F. (1986). Family Dynamics in Individual Psychotherapy: A Guide to Clinical Strategies. NY: Guilford.

Zimmerman, J.K. (1991). Crossing the desert alone: An etiological model of female adolescent suicidality. In C. Gilligan, A.G. Rogers, and D.L. Tolman, eds., Women, Girls, and Psychotherapy: Reframing Resistance. NY: Haworth Press.